# COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

## MEETING MINUTES
## October 23-24, 2014

**Meeting Location:** *Sheraton Burlington, 807 Williston Rd., Burlington, VT 05403*

**Commissioners Present:** David Sanders (Chairman), Hon. Patricia Martin, Amy Ayoub, Teri Covington, Dr. David Rubin, Dr. Wade Horn, Dr. Cassie Statuto Bevan, Michael Petit, Jennifer Rodriguez

**Attending by Phone:** Bud Cramer (Susan Dreyfus and Marilyn Zimmerman were not in attendance.)

**Designated Federal Officer:** Liz Oppenheim, Chief of Staff

**Conduct of the Meeting:** In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Thursday, October 23, 2014, from 8:00 a.m.–5:00 p.m. and Friday, October 24, 2014, from 8:00 a.m. to 3:00 p.m. at the Sheraton Burlington. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect fatalities. Commissioners heard from presenters about child abuse and neglect deaths in Indian Country and the state of the art of safety assessment in public child welfare and related human service arenas. The meeting also explored Vermont's public health strategies for preventing deaths from child abuse and neglect.

Standing in for Chairman Sanders, whose travel was delayed, Commissioner Martin opened the meeting by informing participants that the agenda was very tight and that she was going to keep closely to the times allotted for each presentation. She indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. Finally, she indicated that any audience members wishing to comment could leave written testimony in the designated file at the registration table or submit testimony or written feedback through the Commission's website. She indicated that the meeting was being recorded and asked speakers and Commissioners to speak into the microphones.

## THURSDAY, OCTOBER 23

### OPENING REMARKS: *Commissioner Patricia Martin*

Commissioners introduced themselves, and Commissioner Martin stated the goals for today's meeting.

### PARENT PRESENTATION: *Tammy Simoneau*

Tammy Simoneau is a foster and adoptive parent from Newport, Vermont. She has four biological children ranging in age from 20-26 and has adopted two children with severe special needs. One daughter (now 13) was a victim of shaken baby syndrome (SBS) at 5 weeks. She had been shaken at least three times prior to the final incident. Her son has Hemimegalencephaly and had multiple surgeries at a young age; his biological

mother was young and unable to meet his needs. Her family has fostered other infants with SBS, and she is currently co-fostering (with her own daughter) another child with SBS.

Simoneau noted that there is a general lack of education in the system when it comes to children with special needs, including social work staff, DCF, and biological parents. Services are available to help, but finding them takes a lot of footwork and dedication. Simoneau's primary recommendation is to expand training across the board and increase advocacy for children's needs. In particular:

- More social workers need to be hired so that they will have smaller caseloads and can learn more about children's special needs.
- Foster parents are required to meet certain expectations with regard to caring for children with special needs, but case plans for biological parents seem to address only the minimum amount of education and skill needed to get children back.
- Foster parents' recommendations regarding what biological parents need to know and do to safely care for their children should be treated as "expert opinion" rather than "personal opinion."
- Social workers need to be more involved with children's medical appointments, so that they fully understand children's conditions and needs.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- In the cases of both of Simoneau's adopted children, the child welfare system had opportunities to intervene earlier to prevent the more severe injuries that eventually occurred. In one case, an older sibling had been previously severely injured by the father; in another, an earlier reunification with the biological mother put the child at further risk.
- There is a legal bypass of reasonable efforts allowed by CAPTA, but it is not always employed due to political and other reasons.
- Simoneau cites the following factors for her children's ability to "beat the odds" and survive long past expectations: technology/medical care, resiliency, and foster parents' advocacy and care.
- Fatalities result in a search for justice; more needs to be done to look at children's needs for long-term care in cases of near fatalities and other severe injuries.
- Foster parents are often not consulted about children's needs and vulnerabilities. Simoneau did not have an opportunity to speak to the court on behalf of her children. Some Guradian Ad Litems (GALs) and social workers are wonderful, but others are not as strong at advocating for the children to whom they are assigned.

**VERMONT'S STRATEGIES FOR PREVENTING CHILD ABUSE AND NEGLECT FATALITIES: *Cindy Walcott*, *Deputy Commissioner*, *Family Services Division*, *Vermont Department for Children and Families (DCF)***

Deputy Commissioner Walcott was asked to speak about Vermont's efforts to prevent child fatalities due to child abuse and neglect. Key points from her presentation included the following:

- It's important to understand the nature of what we're trying to prevent. What's happening, to whom, and by whom? Vermont has a very low rate of child abuse and neglect related fatalities (20 from 2007–14); in some ways, this makes it more difficult for staff to develop the skills needed to address the problem effectively.
- Based on the most common causes of death, Vermont's primary focuses have been preventing abusive head trauma (AHT), strengthening the role of fathers, and promoting safe sleep.
    - **AHT.** For more than 10 years, the child welfare agency, health department, and developmental services agency have been funding an AHT prevention program, which is delivered by Prevent

Child Abuse Vermont in all hospitals with maternity units in the state.

  - **Fatherhood.** Child welfare has historically been focused on mothers, but the reality is that children are often in danger from their fathers. Vermont has conducted training for workers on how fathering is different from mothering and how to work with fathers who have perpetrated domestic violence without compromising the safety of family members (the Safe and Together approach). They have held three statewide fatherhood conferences.
  - **Safe Sleep.** Vermont's child welfare agency is concerned about children who die from unsafe sleep, although not all cases are substantiated. In 2012, the state health department developed a tip sheet, which DCF social workers are required to give to parents who have children under age 1 or who are currently pregnant.

- Supporting parents with young children is one of the keys to preventing child maltreatment deaths. Vermont has 14 community parent-child centers to help parents with young children.
- Children's Integrated Services includes a number of formerly free-standing programs (including Part C). Each jurisdiction has a coordinator who directs parents to the correct services in their community for the supports they need.
- Vermont has implemented Nurse-Family Partnership with Affordable Care Act funds, and they are looking into the Strengthening Families framework.
- The state child welfare agency has made a number of changes to get to families sooner:
  - In 2008, they expanded the criteria for child safety intervention—now focused more on a pattern of concerns rather than a single incident. Interventions have doubled in a three-year period.
  - Differential response was implemented in 2009. 40 percent of cases are now handled as assessments.
  - Also in 2009, the state changed criteria so that the decision to offer services is based on risk, not substantiation. Open family support cases increased by more than 500 percent in one year.
- The Commission needs to look beyond child welfare. By the time child welfare sees families, they are in a lot of trouble.
- The rising use of opiates has "changed the safety equation for children."
- Governments must find the courage to invest in front-end prevention. The current federal financing scheme does not support that.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- Opiates have changed the safety equation because of addicted parents' inability to prioritize the needs of their children over their addiction.
- Differential response in Vermont is not designed to "divert families from the system." The state has the same ability to approach the court for custody and provide services as needed, whether the family is receiving an assessment or an investigation. Investigations and assessments are similar in many ways, because in either case, it is important to understand what is happening in the family, what stressors the family is experiencing, and what can be done to get the family back on track.
- The increase in open cases does create concern about the number of social workers available. Vermont has been able to add a significant number of workers twice during the past five years.

**PREVENTING CHILD ABUSE AND NEGLECT FATALITIES IN INDIAN COUNTRY: *Terry Cross, Director, National Indian Child Welfare Association***

Terry Cross is the founder and executive director of the National Indian Child Welfare Association (NICWA). His presentation addressed the historical context of tribal responses to child abuse and neglect, the current status of data and legal/jurisdictional issues, policy and funding challenges that tribes face, how tribes are addressing these issues, and questions to pursue as a Commission. He expressed his hope that his remarks would lay the groundwork for the Commission's further interest rather than represent the end of the discussion. His key points included the following:

- Indian Country is very diverse culturally, economically, and historically. Two thirds of tribal people live in urban areas. The government structures of tribes differ greatly—only about half of tribes have tribal courts. The population of tribes varies from 50 to 500,000.
- Tribes' historical relationship with colonial powers, including complex layers of federal Indian policy, complicates the difficulties in tribal communities.
- When colonial powers take away the children of indigenous populations, it dismembers the culture so that it is nearly impossible to rebuild. This pattern continues in the United States today through the overrepresentation of Indian children in foster care. As late as 1972, there were American Indian (AI) communities that had no children.
- The historical distrust between tribes and the federal government is tremendous. The boarding school period was followed by a period of assimilation and urban relocation. The federal policy of self-determination for tribes has only emerged since the late 1960s and early 1970s. Tribes still lack access to certain federal funding streams, including title XX.
- We do not know enough about the risk factors that affect AI children; they are excluded from major data collection systems, including the National Incidence Study and NCANDS (because no mechanism exists for tribes to report to the NCANDS database).
- What we do know about risk factors for AI children:
    - About 34 percent of AI children live in families that are considered "impoverished." A study of child neglect in Indian Country found that it wasn't just income that indicated whether neglect occurred, it was the "depth of poverty"—e.g., whether the family had access to things like transportation, a washer/dryer, and adequate housing. The neglecting sample actually scored higher on parenting skills than non-neglecting families. A public health response is needed to avoid this problem of neglect.
    - Substance abuse is a significant issue. Approximately 18 percent of adults need treatment for substance abuse, and between 80 percent and 85 percent of child abuse and neglect is estimated to be related to substance misuse.
    - AI families are more likely to struggle with mental health issues and stress from unresolved trauma. They have the highest rates in the nation of youth suicide and adult serious psychological distress and depressive episodes.
    - AI families live in an environment where safety is not assured. A non-Indian adult who comes on to a reservation and abuses a child physically or sexually cannot be prosecuted by the tribe, and only about 2 percent of cases will be prosecuted federally. Policing in many cases is almost nonexistent. There is a feeling of helplessness and hopelessness among youth.
    - AI children have high rates of disability, making them more vulnerable to child abuse and neglect. Poverty and addiction issues increase these children's vulnerability.
    - Common family risk factors include social isolation, lack of services, low income, and domestic violence.
    - Community risk factors include a high concentration of poverty, low access to services, high rates of criminal victimization, and a lack of police protection.

- The definition in the federal Indian Child Protection and Family Violence Prevention Act is different from CAPTA definitions, and state and tribal codes also differ. Cultural understanding of neglect is an issue: poverty, isolation, and lack of access to services are not neglect. The inconsistency in definitions makes it very difficult to know whether current counts over- or underestimate the incidence of child abuse and neglect in Indian Country.
- We do know that AI children are overrepresented in out-of-home care. (For example, in Alaska, 17 percent of children are native, but more than 60 percent of children in out-of-home care are native.) AI children are reported at rates similar to white children but are more likely to be investigated, substantiated, and placed.
- The federal Dawes Act gave every Indian person a plot of land to end tribal ownership of land, resulting in "checkerboard" reservations. This complicates jurisdictional issues. Solutions require local teams and intergovernmental agreements to ensure partnerships and prosecution.
- The lack of funding is a significant issue. Tribes have no access to title XX. Their only access to CAPTA is through discretionary funds. Many tribes do not have access to title IV-E/IV-B. One funding "bright spot" is the Affordable Care Act. Because there is tribal language in the law, tribes are receiving about $50 million for home visiting in 2012.
- NICWA is working with tribes to develop in-home systems of care using the Touchstones of Hope and its five principles: self-determination, holistic approach to services, central use of culture and language, structural interventions to deal with poverty and trauma, and nondiscrimination. They are conducting training to build capacity and develop child protection teams. These efforts are reducing placement outside of villages through a coordinated, community-based approach.
- Cross's hope is that the Commission can support these efforts by influencing federal policy, for example by increasing access to CAPTA funds and funding for the Indian Child Protection and Family Violence Prevention Act.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- The rate for child abuse and neglect fatalities among American Indians is exactly the same as for the mainstream population, but we don't know how good that number is. It's not clear how child fatalities are tracked because there is no mechanism to do that. AI populations also face the same difficulties as other groups in determining whether a death is an accident or the result of neglect. Some of the deaths come back to resources (e.g., unsafe wiring in homes, lack of child safety seats).
- There are many local, informal child protection teams or multidisciplinary teams that gather in communities to try to address the problem and do prevention work. By law, there is supposed to be a team in every community, run by the Bureau of Indian Affairs (BIA), but these have not been implemented. There are also 32 American Indian Centers that provide family support off the reservation, often in partnership with a city, county, or state.
- The Indian Child Welfare Act (ICWA), in addition to establishing criteria for states to take an AI child into custody, also allows states and tribes to enter into agreements for joint investigations. Efforts are most successful (and compliance with ICWA highest) where these agreements exist. What is still needed is legislation for child abuse similar to the provisions of the Violence Against Women Act, which allows tribes to prosecute non-Indians in domestic violence cases.
- Because of P.L. 83-280 (commonly referred to as P.L. 280), 11 states have concurrent jurisdiction over child welfare, resulting in a "race to the courthouse." In these states, there is no federal role. Other tribes, through self-determination laws, have removed themselves completely from federal oversight. But every state and every tribe is different.

- NCANDS does not include AI children served by tribal child welfare systems because tribes do not receive CAPTA funding. Tribes have been advocating for such reporting. Around 2005, NICWA did a study of how it could be accomplished, but nothing has been done with that report.
- The historical trauma may create some reluctance by tribes to remove children who are at imminent risk of harm. NICWA has had success with changing by initiating conversations within communities around the question, "What is a safe child?" As tribes assume self-determination and strengthen their policing, courts, and child welfare programs, there have been positive changes in child protection. It takes time to convince tribal leaders that children are resources that are as important to the tribe as timber and fish.
- The Indian Child Protection and Family Violence Prevention Act was created in the late 1980s due to a lack of prosecution for child sexual abuse on Indian reservations. Congress passed a law requiring mandatory reporting, child protection teams throughout the country, and resource centers to help tribes deal with abuse. It was authorized at $65 million per year, but funds were not appropriated.
- There is no entity in Indian Country that investigates and counts child abuse and neglect fatalities; tribal infrastructure is very different from a states' infrastructure.
- Tribal numbers for neglect are higher than the mainstream population's, but rates of abuse are lower. Culturally, children in general (and children with disabilities in particular) are held in high esteem. The spiritual teaching is that children are sacred gifts from the creator and if they are mistreated they will be taken back by the creator. Cultural beliefs mitigate risk and help protect children.

**UNDERSTANDING THE CHILD WELFARE SYSTEM AND ITS INTERSECTION WITH FATAL MALTREATMENT: EXPERIENCES, LACK OF PREPARATION, AND HOW WORKERS MISS WARNING SIGNS: *Emily Douglas*, *Associate Professor*, *School of Social Work*, *Bridgewater State University***

Dr. Douglas addressed the intersection of the child welfare system and fatal child maltreatment. She provided insight about a survey she created to gauge the knowledge and understanding of risk factors within the child welfare workforce. She also surveyed child welfare workers who had experienced a child fatality on their caseload. Key points from her research included the following:

Dr. Douglas's survey of the workforce relied upon the definition of fatal child maltreatment as captured by NCANDS. According to NCANDS, children are more likely to die from neglect than from physical abuse. The following are some risk factors for fatal child abuse and neglect:

- **Child risk factors:** Age (about half of victims are under the age of 1 and approximately three quarters are under age 3), gender (boys are slightly more likely to die), race (African-American children are overrepresented), children perceived as "difficult" by caregivers, and history of out-of-home placement.
- **Parent/caregiver risk factors:** Moms are more likely to be responsible (because children are more likely to die of neglect and moms do more caregiving). Other factors are age (under 30), experiencing a major life event in the last 12 months (losing job, moving, divorce), unemployment, history of violence in family/household, and a history of mental health or substance abuse concerns.
- **Victim/perpetrator relationship:** Parent perpetrators often report feeling that their child is not respectful or that the child engaged in provoking behavior prior to a fatality. (This illustrates the importance of parental education about appropriate child development and milestones.)
- **Environmental/situational risk factors:** A recent change in household composition, having non-family members present in the household, unemployment, and mobile families/unstable housing. Between 30 percent and 50 percent of the families are known to the child welfare system before their child dies.

In 2010–11, Dr. Douglas conducted an online survey to gain insight into child welfare workers' understanding of risk factors for a child abuse and neglect fatality, services provided to children prior to a fatality,

characteristics of children and families (known to the child welfare system) experiencing a fatality, and workers' experiences following a fatality on their caseload. About the study:

- Sample: Approximately 425 frontline workers and supervisors. 129 had experienced a child fatality on their caseload. (The survey was voluntary and may have drawn special interest from workers who had experienced a fatality.) 90 percent were female, and about 50 percent had a master's degree. The average age was 41, and there was limited racial diversity.
- Survey results revealed a significant gap in knowledge. Only 20 percent of respondents agreed that mothers were more likely to be responsible for a child's death (a true statement). Also, 58 percent of respondents said that children are more likely to die from physical abuse than neglect (not true). About two thirds wrongly responded that a child is most likely to be killed by a nonfamily member.
- A literature review and review of training curricula for child welfare workers in 20 states revealed little discussion or direct training related to fatal child abuse and neglect.
- More than a quarter of those surveyed by Douglas said they had a parent on their caseload reveal that they might kill their child, and about three quarters of the workers surveyed were concerned that a child on their caseload would die.
- Douglas estimates that approximately 3 percent to 4 percent of the child welfare workforce has experienced the death of a child on their caseload. Although headlines and news reports often link child abuse and neglect fatalities to untrained, inexperienced young social workers, there is very little known about the practice behaviors of workers overseeing a case in which a child dies.
- Among survey respondents who had experienced a fatality on their caseload, the median caseload was 25, which is not far from the Child Welfare League of America (CWLA) recommendation of 17 for a front-line worker. The average age of the worker when the child died was 38, and on average, workers had been employed by the agency for six years. Two thirds said they felt the family was being closely monitored prior to the child's death, and about one quarter said the death was unavoidable. Only about 10 percent of them indicated they had wanted to handle the case differently. She acknowledged that the survey results might be affected by self-protection.

Dr. Douglas then moved to a discussion of the increased reliance on strength-based approaches within the child welfare system. She noted that finding strengths is a "necessary and essential component" of child welfare practice, but that there may not be sufficient training or understanding about balancing risks with strengths. There is little research about the impact of strength-based approaches to child welfare.

Dr. Douglas also suggested that risk assessment tools in child welfare can be open to interpretation and overruled by clinical judgment.

Conclusions:

- Workers are deeply concerned about preventing child abuse and neglect fatalities.
- We are currently doing a poor job of training workers to identify and understand risk factors.
- In the absence of this knowledge, workers' own attitudes influence their assessment of risk. Workers may not be assessing risk through the life of a case.
- Discussions around risk factors for fatalities need to be integrated into daily, routine case work, and we need to have conversations about what constitutes a strength and how risks and strengths do not "cancel each other out."

Her recommendations included the following:

- Increase training for child welfare professionals about the risk factors for fatal child maltreatment, and ensure that it is integrated into training for professionals at all levels and in all positions.
- More fully understand the research and practice around concurrently assessing strengths and risk.

- Increase research funding toward identifying risk factors for child abuse and neglect fatalities and serious injuries.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- There are two types of risk assessment tools: consensus-based (based on theory, research, and practitioner opinion) and actuarial (statistically derived). However, the primary concern may not be with the selection of the tool itself but how workers interpret and integrate these tools into child welfare practice. Inexperienced workers tend to find such tools more useful; experienced workers tend to feel that they limit their ability to use their own expertise. In these cases, workers bring their own clinical judgment (and prejudices) to make decisions. The role of supervisors is to encourage workers to think critically about the work they are doing: point workers back to the tools and question why they are not driving decision-making.
- Although there is some ideology and judgment involved, Dr. Douglas does believe that caseworkers and agencies are making efforts to integrate more research, evidence, and assessment tools to improve decision-making.
- It is important to bring a "fatality lens" to training, supervision, and routine casework. At the most basic level, workers need to know: (1) little kids die, (2) more kids die from neglect, and (3) moms are most likely to be responsible for a child's death.
- An important question for future research: When a worker observes a risk factor for child fatality, what do they do next?
- Commissioners indicated a need to look further at NCANDS and other research to develop a more detailed understanding of who the perpetrators are and how many children have prior involvement with the child welfare system before a fatality occurs.
- When asked what she would tell the Commission and the child welfare workforce that could "fundamentally change" the approach to preventing child abuse and neglect fatalities, Dr. Douglas responded: (1) Ensure that the workforce knows what the risk factors are, including the conditions under which a child dies; and (2) Train workers that risk and strengths can be present in families at the same time and that a strength on its own does not cancel out the risk factor(s).

**THE STATE OF THE ART OF SAFETY ASSESSMENT IN PUBLIC CHILD WELFARE: Panel Presentation**

This panel presentation discussed the distinction in child welfare between risk and safety, and explored the strengths and limitations of current safety assessment approaches at different points in the life of a case. It also provided a "street level" view of the challenges case managers face in assessing for safety.

***Theresa Costello, Executive Director, ACTION for Child Protection***

As executive director of ACTION for Child Protection and the former director of the National Resource Center for Child Protective Services, Costello has helped many states develop safety assessment tools and systems. The main points of her presentation include the following:

- Risk assessment was developed in the late 1970s to provide guidelines for practice, optimize the use of available resources, and provide a rationale for service targeting. *Risk* means the likelihood of future maltreatment.
- Risk assessment tools feature two distinct approaches: actuarial classification and theoretical-empirically guided tools.
- Wayne Holder and Michael Corey were the first to introduce safety as distinct from risk, in 1985. Vulnerable children are *safe* when there are no threats of danger within the family or when the parents possess sufficient protective capacity to manage any threats. Children are *unsafe* when

threats of danger exist within the family, children are vulnerable to such threats, and parents have insufficient protective capacities to manage or control threats.

- Determining parents' protective capacity does not involve looking for generalized "strengths"—it requires a very specific assessment of the caregiver's cognitive, behavioral, and emotional capacity.
- Most safety assessment tools look for a common set of safety threats, including the following:
  - Violent caregivers or others in the household
  - A caregiver who makes the child inaccessible
  - Caregiver lack of self-control
  - A caregiver with a distorted or extreme perception of a child
  - A caregiver who fails to supervise/protect
  - Hazardous living arrangements/conditions
  - Intention to harm and cause suffering
  - A child who provokes maltreatment
  - A fearful child
  - A caregiver who is unwilling or unable to meet the child's immediate needs
- There are numerous safety decision points throughout the life of a case. They include: Intake (hotline), initial contact, investigation conclusion, placement (removal, reunification), ongoing cases (in-home and out-of home), visitation, and case closure. It's not just about safety at the expense of well-being or permanency. All three goals must be woven together.
- There are three primary safety models and tools in use today in child welfare:
  - Structured Decision Making (SDM, risk and safety assessment tools)—Children's Research Center
  - Signs of Safety—Andrew Turnell
  - SAFE model—ACTION for Child Protection
- The strengths of current safety approaches/practice include the following:
  - Consensus throughout the field about the most common safety threats
  - Widespread application of assessment for present danger (happening now)
  - Improving implementation fidelity
  - Increasing emphasis on family engagement
- Hybrids of safety approaches reflect the best of each model.
- The limitations of current safety approaches/practice include the following:
  - Inadequate assessment of impending danger
  - Continued confusion regarding safety versus risk
  - Impending danger assessments and planning still lacking
  - Safety management function not well understood or practiced
  - Reunification decisions not always safety-based
- The field continues to face the following challenges:
  - Implementation has historically been focused on training.
  - Recent efforts to apply implementation science are promising but still in the early stages.

- A multiyear, multifaceted approach is costly and requires consistent leadership.

- The following research on safety assessment is needed:
  - Rigorous research on safety models (with a control group—one such study is under way)
  - Interrater reliability analysis
  - Construct validity
  - Fidelity assessments (numerous completed)
- It is not realistic to expect that any safety assessment tool will have the predictive accuracy to prevent all maltreatment-related fatalities. Tools are essential guides to decision-making, and we should strive to improve them, but it's also essential to focus on improving staff skills such as family engagement, critical thinking, and supervision.

***Kyle Hoover, Social Worker, DCF***

Hoover has conducted investigations and assessments out of the Bennington District Office for the past 9½ years, including handling child fatality cases. Key points of his presentation included the following:

- Child welfare casework involves many challenges. Caseworkers must employ their skills and training to engage families, effectively gather detailed information, accentuate protective capacities, and make immediate safety decisions. Many caseworkers feel they never have enough time to effectively plan, respond, and document cases.
- The process for safety assessment in Vermont is as follows:
  1. A call comes to the state's centralized intake unit. The report is entered into the system by a social worker, reviewed by a statewide group of supervisors, and assigned as an investigation or assessment to a local office.
  2. All reports also are screened by a local supervisor, who can accept a report on second read. Each case is then assigned a priority level—response by the end of the workday or within 72 hours.
  3. A caseworker interviews the alleged victim, other children in the home, caretakers, potential witnesses, supports, and the alleged perpetrator, in addition to conducting a home and site visit. The state's practice emphasizes SDM tools. The SDM "Danger and Safety Assessment" tool is to be completed within 24 hours of the initial response; it assesses whether a child is safe, safe with a plan, or unsafe. The SDM "Risk Assessment" tool is to be completed prior to case closure, usually at 45 or 60 days, depending on the type of case. This tool assesses the likelihood of further maltreatment to determine whether DCF should remain involved with a family for a period of at least 3 months.
- The following strengths are present in Vermont's system:
  - The centralized intake model has addressed inconsistencies across the state in acceptance rates and case type. Local "second reads" assure the community that a familiar face with local knowledge will review their concerns.
  - SDM tools are efficient and support focused planning and consistent responses. They help reduce blind spots and elicit further discussion about protective capacities. The risk assessment and its supporting research support family engagement through transparent discussions about risk factors.
  - Advances in technology, such as having access to full records and case notes from the past 10 years, are extremely beneficial. Caseworkers can quickly run a new household member through the system using their cell phones, or have a supervisor or co-worker run the full history and email the results.
  - Access to juvenile justice case notes allows caseworkers to assess history and its potential effect on immediate child safety, whether for young siblings or the juvenile's own infant.

- The availability of multidisciplinary teams is essential in addressing serious cases, including child death. Whether through the local child advocacy center or the various empaneled teams that share common goals related to children, these are the places where relationships are built, opportunities to improve local practice evolves, and a shared stake in improving protection across disciplines is crafted. This is critical on both a state and local level.

- The following are areas for continued improvement in Vermont:
  - **Sharing of historical records across child protective agencies from state-to-state**. Some states are reluctant to share any information; others have clearinghouses for their records, which may take weeks or months to access. For Vermont, a small state with bordering populations in transit and many babies born to out-of-state residents, this presents a major obstacle to assessing safety. **Recommendation: Create agreements for timely, uniform information sharing.**
  - **Inconsistent responses due to different make-up of child welfare systems**. A judge, prosecutor, or even a community agency may greatly affect child safety, beyond any policy, statute, or research-based tool—this is particularly evident in decision-making around removing a child from a home. It also is a factor within systems that don't communicate with partnering agencies, operating in siloes without recognizing a common goal in protecting children.
  - **Retention of supervisors and direct service staff.** Decision-making tools can be overwhelming and feel completely subjective to a new worker. Important relationships within communities are built over time and are lost when workers succumb to burnout, secondary trauma, high caseloads, and long, underpaid hours. **Recommendation: Provide focused training and continue to research best practices with regard to caseload size.**
  - **Lack of funding.** Infants and toddlers are the most vulnerable and need proactive services wrapped around them. A parent's substance abuse, violent history, and mental health issues require adequate treatment options. Without proper funding, agencies have wait lists or are simply unable to serve children effectively.

***Shawn Vetere, Social Worker, St. Albans DCF District Office***

Vetere has been employed by DCF in the child protective services (CPS) unit for the last 4½ years. Her caseloads have included in-home family support cases as well as conditional custody and custody cases. Her key points included the following:

- Caseload sizes and unrealistic workloads impact workers' ability to appropriately address family issues and monitor safety. Workers must be able to devote adequate time to determine whether parents have truly changed or merely complied. It is crucial to be able to visit children in their homes, but due to high caseloads, workers often have to see children at the district office or interrupt their school day or visits with their family.
- It is extremely difficult to monitor and assess safety when serious harm has already occurred. When there is not a consistent report from the family regarding the nature of the harm or how it happened, it is difficult to monitor safety and move forward with reunification.
- Monitoring child safety is further challenged by social workers not being appropriately trained. Foundation courses do not accurately represent the nature of the work or the complexities that families face. Workers are not trained to understand the signs of substance abuse, domestic violence, or the impact of trauma on a child's development. Workers are not initially trained in how to represent a child's needs in the courtroom or how to testify in custody hearings.
- Providers are not adequately trained to understand child safety; many prioritize family engagement over child safety and may even withhold information from the social worker or in team meetings for fear that they will compromise their relationship with the family. Community partners experience a high turnover rate, so families endure multiple workers and critical time is lost rebuilding relationships. These challenges result in a lack of collaboration between agencies, a focus on issues

that did not bring the children into custody, fragmented teams, and the inability to adequately assess and monitor child safety.

- There are limited resources to address the complexities that faced by families, which include mental health, substance abuse, domestic violence, and sexual abuse concerns.
- Family members and kin often come forward with the intent to care for relatives who have entered DCF custody. Sometimes these family members have the same safety concerns that DCF is addressing with the parents. However, without documentation, judges sometimes place children with these kin. Conditional custody orders sometimes do not allow for appropriate oversight.
- Overworked and understaffed state's attorney's offices are frequently unprepared for court hearings, which results in the discharge of custody of vulnerable children back to unsafe environments.
- Guardian Ad Litems (GALs) have sometimes supported the return of a child before safety has been achieved. These decisions are sometimes reached without ever meeting the child or talking to the social worker or caregiver; this can occur with extremely vulnerable children, including infants.
- Lawyers are not focused on urging their clients to change patterns of unsafe behaviors but only on representing their immediate interests; this minimizes the child's safety needs.

***Matthew Bergeron, Social Worker, Family Services Division, DCF***

Bergeron has 11 years of experience in child protection with DCF out of the St. Johnsbury district office. He carries a mixed caseload of ongoing child protection cases, including custody, open family cases, juvenile justice, youthful offender cases, and investigations and assessments. The main points of his presentation include the following:

- All DCF clients are at high or very high risk. Caseworkers must quickly and accurately identify safety concerns and communicate those to providers.
- Safety is dynamic and constantly changing.
- DCF implemented tools to help caseworkers stay focused. SDM has been a very valuable tool.
- Safety is part of day-to-day practice. DCF uses a teaming model, with family safety planning meetings based on the Signs of Safety model.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- Vermont caseworkers sometimes go out on investigations in multidisciplinary teams, especially with law enforcement in cases of child sexual abuse. DCF also has good relationships with some local domestic violence offices.
- Caseworkers often have safety concerns about a family that cannot be proven. In those cases, eyes on the child are particularly important.
- ACTION for Child Protection conducts fidelity assessments of decision-making processes, pulling cases after six months to look for sufficiency of information collection and how that information translates into a decision. The CFSR process is the only formal review; those reviews have found challenges with maltreatment recurrence.
- In Vermont, caseload size varies: one social worker said his caseload was 25-30 children. Another responded that her caseload was 12 families with 30 children. Caseworkers agreed caseloads should be smaller and counted differently: by the number of children, not families.
- Per CAPTA requirements, Vermont has a policy to develop a plan of safe care if the state receives a report of a drug-exposed newborn.

- Asked what he would need to redesign a more effective investigation process, one caseworker responded that he would like more time, more funding for services, a multidisciplinary teaming approach, and trained professionals to address child trauma.
- Social workers should have the time to visit with each child on their caseload weekly.
- Safety and risk assessment tools can seem like a distraction at first, but when they support meaningful face-to-face engagement with families, they add value to the work.

**[Lunch break]**

**ASSESSING SAFETY IN LAW ENFORCEMENT AND KEY INTERVENTION SERVICES: Panel Presentation**

This panel provided information about how mental health, domestic violence, and substance abuse service providers assess and consider the safety of children.

***Lt. Lance Burnham, Vermont State Police***

Lt. Burnham described his work to ensure that state police officers are trained in how to handle and respond to child abuse. In 2010, the Vermont Criminal Justice Training Council made it mandatory for all police to attend 10 hours of domestic violence training.

Cases of suspected child abuse and neglect are high priorities for Vermont law enforcement. Every county is required to have a dedicated unit for abuse and neglect investigations. The goals of these units are to investigate cases and to provide training to first responders in how to recognize child abuse, how to handle it, and the legal ramifications. Since these units were created in 2009, the state has seen fewer instances of inappropriate responses by law enforcement officers.

***Amy Torchia, Children's Advocacy Coordinator, Vermont Network Against Domestic Violence and Sexual Assault***

Amy Torchia described her organization's role in preventing and responding to child abuse and neglect. The Vermont Network offers 14 domestic and sexual violence programs, including nine shelters. While there has been an "incredible increase" in demand for services, they have recently lost funding. About 41 percent to 43 percent of child fatality cases had a domestic abuse record associated with them, according to child fatality reviews. Nonetheless, child fatalities are rare in Vermont. Her key points included the following:

- The organization's counseling efforts include screening for possible threats that put children at risk. An increase in risk for the adult victim also means an increase in concern for the children's safety.
- The state offers a Lethality Assessment Program, which is used to help assess victims of domestic violence for risk of death and engage a community response. This is based on a program in Maryland that reduced domestic violence deaths by 34 percent; it is also being used in hospitals and other settings. Some indicators of lethality include the presence of weapons, threats to kill the adult victim or children, strangulation, drugs, criminal behavior, DCF involvement, and the presence of a stepparent.
- There is also a rural project to increase safety for adult survivors and their children where there is both child abuse and domestic violence. This program is funded by the Office of Violence Against Women, which is collaboration between DCF, Family Services, and the Domestic Violence Network.
- Vermont also uses the Safe and Together Model, a child protection intervention approach that looks at domestic violence and child abuse together. This model is now being used by DCF staff statewide. Critical components look at the perpetrator's behavior (including the pattern of coercive control and actions taken to harm the children), protective behaviors by the nonoffending parent, and the impact on the child.

- What is needed:
  - Research and tools to better assess a batterer's risk of harming children
  - More research about the connection between domestic violence and abusive head trauma and youth suicide
  - Tools to help other systems (e.g., courts) better assess risk and inform decisions

***Jacqueline Corbally, Clinical Services Director, Vermont Department of Health (VDH)***

Jacqueline Corbally spoke about the difficulty Vermont is having with heroin addiction. Currently, opiate admissions exceed alcohol admissions; this is affecting a large number of systems, families, and children. Key points included the following:

- Vermont is working to provide training to clinicians because no one was prepared for dealing with the magnitude of the current problem.
- The state is working across agencies to address these issues. Collaboration has increased between DCF and the Department of Health.
- When families present for formal treatment, agencies need to consider how to treat the family from a system perspective, including how to handle necessary releases and focus on a strength-based treatment plan. Safety assessments for families and children are ongoing, and staff assess risk on a daily basis.

***Kim Coe, Director of Residential and Community Treatment Programs, Lund***

Lund is the only residential treatment program in Vermont serving pregnant and parenting women who are struggling with mental health and addiction issues, along with their children. An Administration for Children and Families Regional Partnership has allowed Lund to offer innovative treatment to women and their families. The grant has several key components:

- An assessment function to identify what each individual family needs
- A play lab to observe and strengthen families
- Co-located substance abuse screeners who go out on initial calls with child welfare workers to provide screenings and address barriers to treatment

Ms. Coe said the project found significant outcomes at the end of five years. Fewer children needed out-of-home placements; there was a decrease in maltreatment reoccurrence; parents had significantly improved timeliness to treatment; and they saw improved system collaboration—all of which resulted in children being safer and families being healthier.

***Charlie Biss, Director, Child, Adolescent and Family Unit, Vermont Department of Mental Health***

Charlie Biss described efforts to provide mental health services to families. He emphasized that having a mental health problem does not mean a person will be a terrible parent. More than 60 percent of children in state custody have parents who have been seen by the mental health system.

One of the chief problems he noted was the fact that mental health is siloed into services for children and services for adults; he recommends instead a well-being approach that focuses and funds services based on the family as a unit.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- Separate funding streams and billing systems can make it difficult for local services to coordinate. Federal constructs do not support collaboration and a focus on prevention, which is key. Suggestions included merging funding streams and/or paying states to achieve particular outcomes.
- There is a need for parity between Medicaid and Medicare; this does not currently exist for substance abuse treatment services.
- Longer-lasting grant funding would be more supportive; programs could spend less time rewriting grants to continue critical programs.
- Law enforcement has faced challenges obtaining records from different agencies. There is some confusion around HIPAA. Sitting down as an interdisciplinary team has helped greatly.
- 42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records posed a challenge for information-sharing within the addiction community. Many licensed professionals believe that they cannot share information because of it. SAMHSA is looking into where this provision fits in with HIPAA.
- Mental health providers cannot supply information without a release, even in an emergency situation. However, the Vermont Department of Mental Health sometimes will offer to go out with an emergency services worker to see what is happening with a family and work with the child welfare agency on a resolution.
- When asked whether the state police had previously been aware of the families in which there had been fatalities in 2013, Lt. Burnham responded that law enforcement was aware of the families but could not comment on open cases. He said it was his personal belief that, in general, communication among agencies needs to be improved.
- Law enforcement agencies are required to enforce protection orders and arrest those who violate them. However, the public's perception is that such an order is "just a piece of paper," and if the victim seeks one, it's going to make things worse. The police cannot provide a 24/7 presence.
- Biss noted that Vermont has accepted a block grant in exchange for greater flexibility within the state's Medicaid system. It has worked well, and they have asked for it to be renewed. The state may be willing to accept capped funds in exchange for greater flexibility in other areas. States must be permitted to "move money upstream" to provide more prevention services.

**WHAT DO WE KNOW ABOUT NEAR FATALITIES THAT COULD ASSIST IN PREVENTING FATALITIES?: *Joanne Wood, M.D., M.S.H.P., Assistant Professor of Pediatrics, Perelman School of Medicine, University of Pennsylvania***

Dr. Wood is a child abuse pediatrician at Children's Hospital of Philadelphia. The focus of her research is caring for victims of abuse with severe injuries, and for the past five years she has participated in near-fatality and fatality reviews in the city of Philadelphia. Dr. Wood presented on the definition of near fatality, how near fatalities are similar to and different from fatalities in terms of prevalence and risk factors, and recommendations for incorporating near-fatality cases into current data collection systems. Key points included the following:

- The definition of a near fatality (per CAPTA) is "an act that is certified by a physician and places the child in serious or critical condition."
- There are several issues with this that may result in under-certification:
  - *Near fatality* is not a medical term.
  - Definitions are not standardized (e.g., *serious or critical*).
  - Physicians are rarely asked to certify that an act of abuse caused a patient's condition.

- As of 2011, when the Government Accountability Office (GAO) report was released, 32 states had defined *near fatality*, and those definitions vary. Nineteen states had started collecting aggregate data about near fatalities (age, gender, demographic characteristics); some were collecting just the number of near fatalities, whereas others were reporting case histories.
- Why study near fatalities?
  - Near fatalities are more common than fatalities but have many common child characteristics (under age 4, more boys than girls), perpetrator characteristics (mothers and fathers), and risk factor profiles (including prevalence of criminal history, substance abuse, and domestic violence).
  - Studying near fatalities (alongside fatality reviews) can provide a larger number of cases to support more accurate trend monitoring, comparisons among localities, assessment of risk for subpopulations, and evaluation of programs and policy.
- Pennsylvania Act 33 requires fatality and near fatality reviews for every child for which there has been a report to CPS.
  - A multidisciplinary team must be convened within 31 days of a report being made. The goal is to look at how CPS and other county agencies are serving that child and family, including both strengths and deficiencies. What kind of practice and policy changes could be made to prevent future fatalities and near fatalities?
  - The report and recommendations to the state are made within 90 days.
  - More than 400 cases have been reviewed to date, and more than 140 recommendations have been made in Philadelphia County alone. An annual report details what changes have and have not been made, based on the recommendations.
- Limitations or challenges to using near-fatality data include the following:
  - NCANDS does not have a near fatality data field, so national data does not currently show how many children have severe injuries and near fatalities.
  - Variation in the state definitions of near fatality make it difficult to compare across states or to aggregate and combine numbers from multiple states.
  - Not all states are collecting this data.
  - There is a lack of core data elements across the states.
- Dr. Wood's recommendations included the following:
  - Clarify the definition of *near fatality* from the Children's Bureau (at the federal level), including the following:
    - Clarify the role of physicians in making this determination.
    - Remove or change the phrasing of the requirement for a physician to "certify an act."
    - Provide guidance to physicians and providers on the definition of *serious or critical condition*, and develop tools and tip sheets for support.
  - Collect and report common near fatality data for all states, including numbers, risk factors, perpetrators, and family circumstances.
    - Support this data collection through coordination with child death reviews and improved communication among different agencies.
    - Support states in conducting near fatality and fatality reviews, and use these reviews to inform local practice and policy.
  - Use hospital administrative data, medical claims data, and data from research networks to look at the rate of children hospitalized with injuries from abuse across the United States. These data are based on a diagnosis (abuse) that isn't subject to changes in policy/practice.
    - Challenges: These diagnoses are mostly limited to physical abuse (rather than neglect), and hospitals are not necessarily consistent about using abuse codes.
    - Develop and validate standardized definitions for abuse-related medical codes.

- Improve utilization of child maltreatment diagnosis and cause-of-injury codes.
- Collect and report core data elements of serious injury from abuse, either by adding these core elements to hospital databases or creating a separate child maltreatment database.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- It is not known exactly how many states have near-fatality review teams. What cases are reviewed differ by state. In the GAO report, more than half of states said they would like more assistance in reviewing and collecting data on near fatalities, in order to help inform their prevention efforts.
- In many cases, child death reviews and near-fatality reviews are happening in parallel. There is a lack of communication or coordination between the two, and often there is some duplication of effort. In Pennsylvania, the near-fatality review is really focused on looking at the county agencies and what they could have done differently. That can be very helpful, but one of the limitations is that these reviews don't have any power over non-county agencies. Sometimes, it is the doctors who need to make changes.
- If you look at child welfare data (where it is available), it appears that fatalities and near fatalities occur in approximately equal numbers. But if you look at the medical data and use a broader definition of near fatality, then it becomes clear that there are more near fatalities.
- If data could be extracted from near-fatality review reports without being linked to an individual child, then the data could be used more widely with confidentiality still being retained.
- In Philadelphia, county staff are fairly aggressive in asking, when an injury is reported, "Is this a near fatality?" If the reporting professional is not sure, a child abuse pediatrician is called to help with identification and certification of cases.
- Often the only difference between a fatality and near fatality (for example, in an abusive head trauma case) is the availability of fast, aggressive medical care. Whether that child dies or not, they will still suffer severe brain injury and may never walk or talk.
- Near fatality reviews in Philadelphia serve parallel purposes. The official goal is to extract the systemic issues and make recommendations. In practice, however, they serve a purpose of also supporting collaboration around that particular case as it moves forward.
- There is a need to create standardized, agreed-upon ways that all hospitals are going to use diagnosis codes to identify children who have suffered near-fatal abuse and neglect. The CDC has done some work in this area, specific to abusive head trauma. Further support might come from research funding, from NIH or elsewhere.
- Rather than focusing on requiring hospitals to provide data, Dr. Wood suggested focusing on improving the quality of data that many hospitals already provide voluntarily. Hospitals also need support in standardizing evaluations for child abuse and neglect, so more cases are detected.

**UNDERSTANDING THE CURRENT PUBLIC HEALTH INFRASTRUCTURE AND HOW IT WOULD NEED TO CHANGE TO ENHANCE PREVENTION OF CHILD MALTREATMENT FATALITIES: VERMONT'S PERSPECTIVE: Panel Presentation**

This panel examined the role of public health in the prevention of child fatalities due to maltreatment. It identified promising strategies in Vermont and addressed the following question: If a public health focus is adopted for prevention of fatal child maltreatment, what are the implications for the infrastructure of public health services across the nation?

***Breena Holmes, M.D., Director of Maternal and Child Health Division, Vermont Department of Health (VDH)***

Dr. Holmes's division of VDH oversees the WIC program; school health; Medicaid's Early Periodic Screening, Diagnosis, and Treatment program; services for children with special health needs; and federally funded programs for home visiting, injury prevention, reproductive health, domestic and sexual violence prevention, and Linking Actions for Unmet Needs in Children's Health (LAUNCH). Her key points included the following:

- Vermont is deeply engaged with the Bright Futures guidelines.
  - This is a set of principles, strategies, and tools that are theory-based, evidence-driven, and systems-oriented, and that can be used to improve the health and well-being of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family, clinical practice, community, health system, and policy levels.
  - The state has done about 10 years of outreach to primary care practices to ensure that everyone knows about the guidelines.
  - The medical home (and health/preventive health care in general) is a great place to start to prevent child maltreatment and fatalities.
- Nurse-Family Partnership is the state's funded program for home visiting; it was selected because of its strong evidence base.
- The state also has an Early Learning Challenge Race to the Top grant, which is funding Parents as Teachers and MESH to supplement visiting for families not covered by NFP.
- Vermont is employing the Strengthening Families framework across the human service agency.
  - Strengthening Families began in the area of child maltreatment and focuses on five protective factors.
  - Vermont uses this framework to assess families pre- and post-services.
- Help Me Grow is the state's umbrella for coordinating early childhood services.
  - It was created to find children who were not developing normally, but it became a place where families could connect about their children's social/emotional development and build protective factors.
  - Vermont is the 25th state to implement this program.
- Dr. Holmes's recommendations included the following:
  - A commitment to primary prevention is needed.
  - Health reform efforts need to include services to support adults within the child's medical home (e.g., screening/treating new moms for depression).
  - Sustainable funding is needed for evidence-based home visiting.
  - The Strengthening Families framework should be further fleshed out and utilized more broadly.

***Beth Tanzman, M.S.W., Assistant Director, Blueprint for Health***

Blueprint for Health is Vermont's statewide patient-centered medical home health initiative. Ms. Tanzman provided testimony to explain how Vermont's Medicaid plan is used to help prevent child maltreatment and fatalities, and to respond to the state's opioid addiction epidemic. Her main points included the following:

- Vermont's Medicaid plan is funded through a Section 1115 Medicaid Demonstration Waiver, which began in 2005 and has been extended through 2018, when the state is planning to transition to a single-payer system. Through this waiver, Vermont agrees to stay below a pre-set spending limit and uses the cost savings to flexibly fund services not traditionally supported by Medicaid, including:
  - Increasing insurance coverage for previously uninsured people
  - Increasing and creating new health services to support uninsured and underinsured beneficiaries

  - Investing in public health approaches to health care
  - Supporting the formation and maintenance of public/private partnerships in health care
- Goals for this approach include the following:
  - Increase access to health care.
  - Build public health approaches.
  - Develop innovative quality and outcome-payment approaches.
  - Enhance coordination of care across providers and delivery systems.
  - Control program cost growth
- Blueprint for Health is one example of what Vermont has been able to do through the waiver program.
  - It is focused on primary care because primary care services provide a good opportunity to manage the growth in costs for chronic health conditions and because it primary care centers are well situated to offer effective preventive care.
  - The statutory framework now requires all insurers in Vermont to pay primary care providers more money if they meet national patient-centered medical home standards. This offers a significant incentive for providers to take a more proactive approach to care. (For example: "This family just missed a three-month well-baby check. Let's go find out what's happening with them.")
  - Blueprint also has created community health teams—multidisciplinary teams of nurses, health coaches, social workers, nutrition specialists, community health workers, and mental health counselors who are paid jointly by commercial and public payers and embedded in primary care practices statewide. They expand capacity for population health and complex care coordination and are prepaid. There is no copay for utilization.
  - The Blueprint program has nearly universal statewide penetration and is seeing positive results in terms of decreasing pharmacy usage and linking children to needed services.
- Ms. Tanzman's recommendations include the following:
  - Align federal policies to support timely exchange of information among providers (e.g., child welfare, substance abuse treatment).
  - Ensure universal access to health care services (including parity for mental health and substance abuse treatment).
  - Accelerate the use of "big data" and predictive analytics to identify the children most at risk for child abuse fatalities.
  - Develop the evidence base for effective interventions.
  - Align related initiatives.

***Sally Borden, M.Ed., Executive Director of KidSafe Collaborative; Children and Recovering Mothers (CHARM) Team***

Key points from Sally Borden's presentation include the following:

- CHARM is a multidisciplinary team that coordinates care for pregnant and postpartum mothers with a history of opiate dependence. It is not housed within a single agency but involves a coordinated/ collaborative approach among people from various disciplines and agencies, with the goal of improving health and safety outcomes for babies born to women with a history of opiate dependence by coordinating medical care, substance abuse treatment, child welfare, and social service supports.
- The program serves about 200 patients per year.

- Key elements of the work are as follows:
  - Pregnancy is seen as an opportunity for change.
  - Early access to prenatal care and substance abuse treatment are key.
  - The program supports early child welfare involvement, assessment, and development of safety plans before birth.
  - Services and supports are coordinated, with explicit systems in place for collaboration and information sharing.
- Nationally, admissions of pregnant women reporting prescription opioid abuse have increased substantially. Vermont has the second-highest rate of admissions to state-funded substance abuse treatment programs in the United States. In Vermont, 4 out of 5 opioid-exposed infants are born to women in treatment.
- Vermont has worked hard to make treatment services accessible. Medication-assisted treatment is the standard of care for pregnant opioid addicts, for the health of both the mother and the fetus.
- This group of parents has very complex issues and service needs.
- CHARM partners include the hospital (including the high-risk obstetrics clinic and neonatology unit), community-based substance abuse and mental health agency, child welfare agency, maternal and child health, home health agency/home visiting services, and Vermont Dept. of Corrections.
- Key elements of the program include the following:
  - A shared philosophy: Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants
  - Memorandums of understanding for sharing information and coordinating services
  - Multidisciplinary teams
- The child protection aspect of the program includes the participation of mandated reporters. Through a state policy change, child safety interventions can now begin one month before the infant's due date, allowing for a plan of safe care to be developed before birth.
- The team meets monthly to review cases and focus on key indicators.
- Ongoing challenges include the following:
  - Collaboration requires ongoing work.
  - Patients need a high level of support.

***Sally Fogerty, M.Ed., former Director, Children's Safety Network***

Sally Fogerty is newly retired from the Children's Safety Network. Her key points included the following:

- Fatalities are the "tip of the iceberg." We need to look at broad strategies for creating an environment that's going to keep all children safe; this will also reduce the deaths.
- There is a need to change the paradigm by focusing not just on individuals but entire communities, and by moving funds further "upstream" toward primary prevention efforts.
- All children deserve safe, stable, and nurturing environments, as emphasized in the CDC's Essentials for Childhood program and the Strengthening Families framework.
- It is important to take a public health approach that emphasizes surveillance and focuses on population and community-based strategies. We need more information about the interplay between risk and protective factors.
- In 2009, the CDC conducted an environmental scan of health department efforts to prevent child maltreatment. 82 percent of state health departments agreed that child maltreatment prevention

was an important part of their work, but only 69 percent were doing it, and only 37 percent had codified it into law. Child welfare and public health want the same thing, although they may talk about it or go about it a little differently.

- The scan also asked health departments what are the top five roles for public health agencies to play in preventing child abuse and neglect. They responded:
  - Making referrals to external child maltreatment resources
  - Identifying and targeting at-risk populations
  - Communicating best practices, funding, and training
  - Building capacity for child maltreatment within the state public health agency to support the work of other agencies
  - Conducting surveillance of child maltreatment risk and protective factors
- Fogerty's final recommendations included the following:
  - Support paid leave for a year after the birth of a baby in the family.
  - Support universal, quality child care.
  - Provide universal home visiting (at least one visit for every family).
  - Provide more flexibility in funding. Design funding and programs to allow states and communities to move away from siloed efforts.
  - Strengthen population and community-based efforts.

***Commissioner Discussion***

Commissioners' comments and questions yielded the following additional points:

- CHARM is a voluntary program. The majority of participating mothers sign a release of information that allows the program to provide a coordinated approach and support services. More research is needed to assess long-term child welfare outcomes. There is a lot of focus on the highest risk families and most urgent needs. If a mother is stable for a few months, she tends to fall off the radar. Most mothers are connected with some follow-up through home visiting or parenting education.
- Health Home is another program that supports Vermont residents with opioid addiction through medical homes. They have embedded a nurse and a licensed mental health addictions counselor within every practice that is prescribing medication-assisted treatment. The service is free and deployed statewide; evaluation results are not yet available.
- Blueprint just received permission to match corrections/incarceration data against their current cohort of program participants; they suspect some of the cost savings are being realized beyond the health system.
- Concern was expressed that "strengthening families" approaches often leave out the fathers, who are often perpetrators of fatalities. Home visiting models in Vermont do intentionally address father engagement whenever possible. A program addressing smoking cessation has found increased success when fathers are engaged, along with pregnant mothers.
- There is a board-certified child abuse pediatrician in Vermont who serves as the medical provider at the major medical center that does child abuse and sexual abuse evaluations. She also plays a prevention role by training community hospital workers. Funding for her services has been complicated and challenging to sustain.
- There has been some talk about broadening investigative teams to include social workers, medical providers, substance abuse professionals, and more.
- It is not known how many of the children who died in Vermont were previously involved in public health programs. These data are not currently sufficiently linked. Child death review might be one way to find this out, but even if it could be determined within the state, the information will not be

available for families who have crossed state lines. (This is particularly challenging in New England.)

- There needs to be two sets of data. Some personal information about families may need to be shared across systems in order to provide services effectively. However, data used for research should be de-identified to protect family privacy. Agencies often assume families will not want their information shared without taking the time to explain how and why sharing information across systems might be beneficial and allowing families to make that decision for themselves.
- Primary care medical homes are talked about as a public health solution that is "upstream" from child welfare, but they are not operating that way yet. Information should not just flow from primary care when they decide to make a report; primary care doctors should be getting information from child welfare, emergency rooms, etc. about the families in their care. Alternatively, medical homes may need to do more of their own screenings and assessments. This may require changing the way that primary care practices are paid.

### CLOSING REMARKS: *Judge Martin*

Judge Martin thanked the panelists and closed the first day of hearings.

## FRIDAY, OCTOBER 24

During the morning of Day 2, Commissioners met in a closed session to gather information, discuss administrative matters, and prepare for future public hearings and deliberations. Public deliberations resumed in the afternoon.

### DELIBERATIONS: *Counting*

Commissioner Sanders opened the afternoon meeting by framing the key questions related to counting child abuse and neglect (CAN) fatalities:

- What is the purpose of counting CAN fatalities?
- What data are currently collected, and how effectively are CAN fatalities currently measured?
- What are the most effective short- and long-term strategies to improve the count?

Commissioner Covington provided an overview of the testimony and recommendations made to the Commission to date on the subject of counting. Key points included the following:

- In general, the purpose for counting is to understand the scope of the problem and to determine whether interventions are working. This information also helps to garner public attention and financial support.
- Many systems capture child fatalities, but they count for different purposes. Commissioner Covington offered a number of case examples to demonstrate how a child's death may be counted very differently depending on the system counting (e.g., child protection, law enforcement, vital statistics, or child death review teams).
- CAN fatalities are said to be consistently under-reported and underestimated due to inconsistencies in how states define CAN fatalities and what data they voluntarily submit to NCANDS.
- In 2008, the Centers for Disease Control and Prevention (CDC) initiated a project to create standardized definitions of CAN. This led to an effort in Michigan and two other states to enlist wider surveillance in determining when CAN fatalities occur. As a result of that project, Michigan has increased the number of fatalities reported to NCANDS. Other states (such as California) have improved their count through reconciliation audits that draw data from multiple sources.

- States tend to do pretty well when counting physical abuse, but neglect fatalities (including those related to egregious supervisory neglect, failure to thrive, failure to use generally accepted safety devices, drug impairment, unsafe sleep, etc.) are counted less consistently and reliably. Commissioner Covington cited testimony the Commission has received about the impact of cultural norms and other forms of bias.
- The Air Force has worked to create validated and operationalized definitions and decision-making tools to increase reliability of substantiation decisions across teams in different parts of the country.

Recommendations proposed thus far to the Commission include but are not limited to the following:

- Create a new national system of surveillance for child maltreatment fatalities.
- Field-test uniform definitions similar to the Air Force model, and/or incorporate definitions prepared by the CDC.
- Strengthen the existing network of child death review teams to create a national system that would provide a public health count of child maltreatment deaths.
- Determine which data systems are most cost effective.
- Provide uniform definitions to NCANDS and the National Child Death Review data system.
- Improve identification of child abuse and neglect fatalities on death certificates, through the addition of a "check box" for child maltreatment.
- Improve death investigations themselves—for example, by developing standardized tools, training medical examiners and coroners, and/or requiring nonmedical coroners to defer to a forensic pathologist regarding cause of death.

***Commissioner Discussion***

Deliberations among Commissioners raised the following additional issues:

- Commissioners considered whether it makes sense to recommend improvements (such as uniform definitions and enhanced guidance) that would strengthen reporting of child abuse and neglect fatalities within NCANDS, or whether it would be better to recommend a different system altogether.
- In response to concerns about the fact that NCANDS counts fatalities only to children who are previously known to a CPS agency, it was suggested that the Commission consider changing the definition of "children known to CPS."
- Chairman Sanders asked Commission staff member Dr. Rachel Berger to provide some insight about the costs of the various data systems currently in use. Dr. Berger explained that the answer to this question is complicated by the fact that the systems in question (e.g., NCANDS, death certificates, law enforcement) do far more than count fatalities. For example, they collect a large amount of data related to fatalities, including risk factors, perpetrator information, etc. They also collect a large amount of data unrelated to fatalities. So we should actually look at the cost of the entire data system as it relates to maltreatment fatalities.
- Commissioners briefly discussed the Air Force work and how it seems to have been effective in removing much of the bias involved in making substantiation determinations. Some Commissioners wondered whether this model could be implemented throughout all states, and if so, where would be the best place to implement it (e.g., child death review teams). The model would need to be adapted to be fatality specific and field-tested in a variety of jurisdictions for validity.
- Some Commissioners expressed concern that changes to how fatalities are counted might interfere with the ability to hold perpetrators and systems accountable and to provide incentives for systems improvement. Others noted that a common side effect of the child fatality review process is greater accountability through enhanced cooperation between law enforcement and CPS. Some Commissioners questioned whether a direct link exists between counting and culpability/

accountability. Other mechanisms (such as children's advocacy centers) might be better suited to the purpose of holding perpetrators accountable for their crimes.

- Commissioners wondered about the status of recommendations that were made in the 2011 GAO report. How did agencies (such as HHS) respond to these recommendations? Staff were asked to research and report on this.
- Commissioners were reminded that it will need to be clear to whom each recommendation is directed (state policymakers, federal legislators).
- Counting is important, but ultimately the goal must be to intervene *before* a child's death. How can teaming strategies (such as those used in reviews *after* a child has died) be implemented before a death occurs? It was suggested that the Commission invite further testimony from teams that have MOUs in place and are working together effectively to prevent fatalities. Chairman Sanders pointed out that the two goals are not mutually exclusive: the Commission has a responsibility both to identify ways to improve the reliability of the count of CAN fatalities and to improve interventions and investigations.
- Attention should be given to prevention (and counting) of fatalities due to systems neglect (e.g., suicide while in foster care or the juvenile justice system). Similarly, more accurate data are needed about child maltreatment fatalities in Native American communities.
- There was some discussion about whether Commissioners all share an understanding of what is meant by a "public health model." It was proposed that a public health model would result in a more objective approach to counting through the use of standardized definitions and tools. It was generally agreed that such a model would expand the count beyond those children known to the child welfare system. There is a need to explore further who should make the determinations about which deaths are included (e.g., coroners, medical examiners).
- Several Commissioners remarked on testimony showing similarities between fatalities and near fatalities. It was proposed that further consideration of near fatalities may support several Commission goals, including enhancing accountability for both perpetrators and systems, providing a model for expediting reviews, improving information sharing, and ensuring better utilization of existing laws (e.g., ASFA's bypass of reasonable efforts).
- Some Commissioners feel there is a need to upgrade the capacity of child fatality review teams, perhaps through an increase in resources directed toward those reviews and teams.

In closing, Chairman Sanders reminded Commissioners that the counting work was sequenced early in the process so that recommendations could be made before the Commission concludes its work and issues final recommendations. Today's presentation was intended to provide a "lay of the land" and to encourage deliberations about what any new tool to count CAN fatalities should encompass. He summarized next steps for the Commission on this issue, as follows:

- Inventory the recommendations made in the 2011 GAO report on the subject of counting. What progress (if any) has been made toward implementing these recommendations?
- Analyze recommendations made at today's meeting. What is required to realize each recommendation (e.g., new statute, regulation, guidance to states)? To whom should each recommendation be directed (e.g., HHS, Congress, states)?
- Revisit the purpose of counting with an eye toward how it is linked to oversight and accountability.
- Revisit the definition of "children known to CPS."
- Consider how best to address children who die from systems neglect (e.g., children who die in foster care, suicides).
- Look at the issues around counting CAN deaths of American Indian/Alaska Native children.
- Further explore the issues related to counting and reviewing near fatalities.

**DELIBERATIONS:** ***Confidentiality***

Chairman Sanders next turned the discussion to the issue of confidentiality. Commission staff member Hope Cooper summarized the testimony presented to date and noted that the issue of confidentiality does not rest in any one work area of the Commission but affects the work of many subcommittees.

Key points from her presentation include the following:

- In federal statute, confidentiality and information-sharing rules are nested within CAPTA, the Privacy Act of 1974, HIPAA, title IV-E and title IV-B of Social Security Act, and Public Health Service Act programs.
- In CAPTA, there is a clear statement about the need for state agencies to safeguard the privacy of child abuse and neglect information. This is an overarching principle, and state laws reinforce that. CAPTA has been amended over the years to allow/permit sharing of information in some circumstances, and in some cases it now requires information sharing (with respect to fatality).
- Studies conducted by GAO indicate that better guidance from HHS is needed around this issue. To date, such guidance has come through regulation, and more recently in the Child Welfare Policy Manual. These two mechanisms for guidance are not necessarily updated at the same time or consistent with each other. (Regulations have not been updated since 1990 and are out of date with respect to CAPTA.)
- Most recently, HHS issued a Confidentiality Toolkit (August 2014) as part of a larger interoperability initiative. This initiative is being driven by changes in technology, implementation of health laws (including electronic health records) and health information exchange, and the need to coordinate programs at a state level. The toolkit has an entire chapter around child welfare programs.
- Other important issues raised by presenters to date include the following:
  - Data sharing across state lines
  - Data and public disclosure around near fatality cases
  - Assessment of state laws that address immunity protections
- Next steps for the Commission might be to better outline the legal/administrative requirements related to information sharing and public disclosure in fatality cases, while continuing to hear from additional experts. One speaker proposed was someone from the Children's Advocacy Institute, which produces a report rating the states on public disclosure laws every few years.

Chairman Sanders then asked Commission staff member Tom Morton to report on his review of a number of reports from state and local task forces and commissions. Morton reviewed eight reports or audits. Of more than 200 recommendations, there was only 1 related to transparency in fatality cases. There were other broader recommendations on transparency, but they were related to other issues such as wait time for services, frequency of visits, etc. He noted that these reports may not be representative, but it was interesting that there were few recommendations about risk factors and only one on transparency in fatality cases.

***Commissioner Discussion***

Deliberations among Commissioners raised the following additional issues:

- In discussing confidentiality and information sharing, particularly around behavioral health records, it will be important to differentiate between a child's records and a parent's.
- Several Commissioners discussed the potential impact of public disclosure on the lives of victims, particularly in the age of electronic records and media. It was proposed that there are three elements to this issue: confidentiality, security, and privacy.

- Commissioners further recognized that there are times when restricting information is important (such as when private information released to the media may impact the lives of children and surviving family members far into the future), and times when confidentiality rules may be used inappropriately to restrict interested parties (e.g., foster parents) from receiving critical information. It is important for agencies to be mindful of their purpose and intent when releasing information.
- In general, Commissioners agreed that agencies (and their staff) should not be permitted to "hide behind a banner of confidentiality." Confidentiality laws must not impede access to information that will translate into accountability and systems improvement.
- Commissioners shared their experience with specific approaches to openness in courts and county services. In one case, a presumption of openness was overturned by a higher court, in part because of opposition from youth. In another case, the movement of closed courts to a presumption of openness was found to have little impact with regard to the frequency or type of media coverage.
- Cases often are criminally prosecuted, so different rules apply and many of the details of the case become available to the public.
- The National Council of Juvenile and Family Court Judges advocates for courts to be presumed open. Commissioner (Judge) Martin noted that she tries to provide the media with information but with firm parameters about what they may not report (e.g., identifying information, photos). She also noted that she has made her court available to surviving siblings asking to change their last name as a result of a high-profile case.
- However the Commission ultimately decides to address the issue of confidentiality, it should be resolved so that regulations cannot be applied unevenly, depending on system needs or desires. One proposed recommendation is to encourage HHS to provide more clarity in its guidance, particularly with regard to distinguishing between information that is shared to promote appropriate and needed interventions for the child versus what information the public receives.
- It may be worthwhile to look at the applicability of the Family Educational Rights and Privacy Act (FERPA) to all children involved with child welfare, not just those in foster care.
- There are opportunities to promote improved information sharing through a commitment to teaming in CPS cases, so that sharing information is focused on the critical goal of protecting the child.

In closing, Chairman Sanders said that further work and direction related to confidentiality and information sharing will be taken up by the Commission's subcommittee on children known to CPS.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

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David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

1/22/2015

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Date